



HUMANA - VisionCare

SUBSCRIBER/EMPLOYEE SERVICE FORM

Subscriber/Employee Status Changes

GENERAL INFORMATION

Subscriber (Employee) Name: _____

Social Security Number: _____ - _____ - _____ Group No. _____

Group Name: _____ State of Arkansas _____

DEPENDENT INFORMATION - ADDITIONS/DELETIONS

Add Dependent(s):

Spouse: _____ Effective Date: _____ Date of Birth: _____

Child: _____ Effective Date: _____ Date of Birth: _____

Child: _____ Effective Date: _____ Date of Birth: _____

Child: _____ Effective Date: _____ Date of Birth: _____

Delete Dependent(s):

Name: _____ Effective Date: _____

Name: _____ Effective Date: _____

CHANGE OF NAME, ADDRESS OR TELEPHONE

Name:

From: _____ To: _____

Address:

Address: _____ Apt. #: _____

City: _____ ST: _____ Zip Code: _____

Telephone Number(s): Home: () _____ Work: () _____

OTHER

Cancel Policy: Effective Date: _____ Reason: _____

Comments: _____

PERSON INITIATING REQUEST (Employee, Administrator, etc.)

Signature: _____ Date: _____

**PLEASE COMPLETE THE FORM AND SEND IT BACK TO YOUR
PAYROLL REPRESENTATIVE AT YOUR AGENCY**